EXHIBIT A

IR ANGIO CEREBRAL ARTERY BILATERAL
IR EMBOLIZATION NEURO BRAIN OR SPINAL CORD

Status: **Final result**

Imaging Links

PACS Images

Virtual Consult

Signed By

Signed	Date/Time	Phone	Pager
ARCOT, KARTHIKEYAN M	Nov 25, 2016 5:15 PM	718-630-6756	

Study Result

PRE OPERATIVE DIAGNOSIS: High-grade symptomatic stenosis of the right common and internal carotid artery for carotid stenting

POST OPERATIVE DIAGNOSIS:
1. Successful endovascular angioplasty and stenting with embolic protection of the high-grade symptomatic stenosis of the right common and internal carotid artery with significant resolution of the previously noted stenosis

PROCEDURE: Angioplasty and stenting of the right common and internal carotid artery with embolic protection

REFERRING PHYSICIAN: Dr. Liff

DATE OF SERVICE: 11/23/2016

SURGEON: Dr. Arcot

CO-SURGEON: Dr. Tiwari

FIRST ASSISTANT: Dr. Selas

CONSENT: Informed consent was obtained for the procedure after discussing the potential risks and benefits of the procedure. Potential risks such as vascular injury, vascular occlusion, further stroke, intracranial hemorrhage and even death were discussed. After all questions were satisfactorily answered, the patient gave informed consent.

ANESTHESIA: General anesthesia

PREOP MEDICATIONS: None

INTRODUCTION: A timeout procedure was documented, the patient's name date of birth and medical record number as well as the procedures to be performed was confirmed by the entire team, after everyone in the room agreed, the procedure continued. After the patient was placed under anesthesia, both groins were prepped and draped in the usual sterile fashion.

Using sterile Seldinger technique the right common femoral artery was punctured using a micropuncture kit. Over a 3mm J wire a 5 French sheath was introduced into the artery and then hooked up to a continuous heparinized flush system.

Via the sheath a 5 French Davis Catheter was introduced over a 0.35 Terumo glide wire, into the abdominal aorta, the catheter was than double flushed and subsequently hooked up to a separate continuous heparinized flush system. The following vessels were than sequentially selected. Digital angiographic acquisitions were than obtained:

VESSELS SELECTED:

The left common carotid artery was selected cervical and cranial views were obtained.

The left vertebral artery was selected cervical and intracranial views were obtained.

The right common carotid artery was selected cervical and cranial views were obtained.

Right common femoral artery was injected with pelvic views.

4 Follow-up angiograms were performed

DIAGNOSTIC IMAGING FINDINGS:
The diagnostic catheter was navigated over the arch using and 035 glide wire.

The left common carotid artery was selected and injected with cervical views.
The left common carotid artery appears normal without any areas of irregularity of stenosis.
The left external carotid artery appears normal without any areas of irregularity of stenosis.
The left internal carotid artery demonstrates some irregularity in the region of the carotid bulb without any significant stenosis.

The left common carotid artery was selected and injected with cranial views.
The left internal carotid artery was normal without any areas of irregularity of stenosis.
The left ACA appears normal without any areas of irregularity of stenosis. There is filling of the contralateral anterior cerebral artery via the anterior communicating artery.
The left MCA appears normal without any areas of irregularity of stenosis.

The left vertebral artery was selected and an injection was performed cervical and cranial views.
The left vertebral artery appear normal without any areas of irregularity of stenosis.
The basilar artery appears normal without any areas of irregularity of stenosis.
The left PICA is visualized and appears normal without any areas of irregularity of stenosis.
Bilateral PCAs are visualized and appear normal without any areas of irregularity of stenosis.
There is significant collateral supply to the right mca territory from the right PCA via the right PCOM.
There is nonocclusive thrombus in the angular branch of the right MCA.

The right common carotid artery was selected injected with cervical views.
The right common carotid artery demonstrates plaque near the bifurcation.
The right external carotid artery appear normal without any areas of irregularity or stenosis.
The right internal carotid artery shows a high-grade stenosis at its origin measuring approximately 88%.

Right common carotid artery was injected with cranial views.
Right internal carotid artery appears normal without any areas of irregularity or stenosis.
Right external carotid artery appears normal without any areas of irregularity or stenosis.
There is poor opacification of the right MCA territory due to washout from the collateral supply

INTERVENTION:
The patient was moving significantly and thus it was decided to intubate him at this time. Laryngeal Mask airway was used

The right external carotid artery was selected and here the catheter was exchanged for a 9 French sheath and the MOMA device using an exchange length a advantage glide wire wire.

An injection of the right common carotid artery was performed via the MOMA device to confirm placement.
The external carotid balloon segment of the MOMA device was in the external carotid artery.
External carotid artery balloon was inflated and the advantage glide wire was carefully withdrawn.

A SYNCHRO 2 wire was then navigated past the stenosis into the petrous internal carotid artery.
A 6 x 40 peripheral balloon was navigated just proximal to the stenosis.
The common carotid artery balloon was inflated and aspiration was turned on.
The balloon was then navigated and positioned across the area of maximal stenosis and inflated under fluoroscopy while aspiration was turned on. There was significant relief of the stenosis and the balloon was deflated.
The balloon was withdrawn. Aspiration was turned off

A 6 x 40 precise stent was navigated just proximal to the stenosis. Aspiration was turned on
The stent was positioned appropriately across the stenosis and deployed. The aspiration was turned off and the pusher was withdrawn.
Aspiration was continued for 30 seconds.
The external carotid artery balloon was deflated.
Aspiration was continued for about 30 seconds.
The common carotid artery balloon was deflated.
Aspiration was continued for a further 30 seconds.

Follow-up angiogram 1:
An injection of the right common carotid artery was performed with cervical views.
It revealed excellent positioning of the stent with significant resolution of the stenosis. There appeared to be mild vasospasm distal to the stent.
Right external carotid artery was occluded by the moma device.
Right common carotid artery appear normal without any significant stenosis.

Follow-up angiogram 2:
Injection of the right common carotid artery was performed with cranial views.
The right internal carotid artery appear normal without any areas of irregularity of stenosis. The right MCA appears normal without any areas of irregularity of stenosis.
The flow is significantly more robust and improved in the territory of the right MCA. The previously noted nonocclusive thrombus is not visualized at this time.

Follow-up angiogram 3:
An injection of the right common carotid artery was performed with cervical views.
It revealed excellent positioning of the stent with significant resolution of the stenosis. There appeared to be mild vasospasm distal to the stent.
Right external carotid artery was occluded by the moma device.
The decision was made to give 5 mg of verapamil intra-arterially at this point and it was injected via the moma device with careful monitoring of blood pressure over 5 minutes.
Right common carotid artery appear normal without any significant stenosis.

Follow-up angiogram 4:
An injection of the right common carotid artery was performed with cervical views.
It revealed excellent positioning of the stent with significant resolution of the stenosis. There was improvement in the spasm distal to the stent.
Right external carotid artery was occluded by the moma device.
The MOMA device was removed.
Right common carotid artery appear normal without any significant stenosis.

The right common femoral artery was selected and injected with pelvic views.

Right common femoral artery, right superficial and deep femoral arteries appear normal without any areas of irregularity of stenosis.

Hemostasis was obtained using a Angio-Seal 8 French device

The patient tolerated the procedure well. There were no complications during the procedure.

Impression:
1. Successful endovascular angioplasty and stenting with embolic protection of the high-grade symptomatic stenosis of the right common and internal carotid artery with significant resolution of the previously noted stenosis

INTRAOPERATIVE MEDICATIONS:
Verapamil

RADIATION DOSE:
AP 22.5 min/ 532.38 mGy
Lat: 20 min/202.65 mGy

MATERIALS UTILIZED:
Diagnostic angiography kit
6 mm x 40 mm precise stent
6 mm x 40 mm Sterling balloon

If you have any questions regarding this procedure or regarding the patient please do not hesitate to contact us at 718-6301270.

Sincerely,

Karthikeyan Arcot, MD
Vascular and Interventional Neurology
Interventional Neuro Associates

Final Report: Dictated by and Signed by Attending Karthikeyan Arcot MD 11/25/2016 5:15 PM

External Result Report

External Result Report

Result History

Order 155869500

IR ANGIO CEREBRAL ARTERY BILATERAL (Order 155672422)

IR EMBOLIZATION NEURO BRAIN OR SPINAL CORD (Order 155869500)

Imaging

Date: **11/23/2016** Department: **Lm 3c** Released By: **Giuseppe T Montagna (auto-released)**
Authorizing: **Jeremy M Liff, MD**

Order Information

Order Date/Time	Release Date/Time	Start Date/Time	End Date/Time
11/23/16 07:35 PM	11/23/16 07:35 PM	11/23/16 07:45 PM	11/23/16 07:45 PM

Order Questions

Question	Answer	Comment
Reason for exam:	**r ica stenosis, stroke**	

Note: Enter reason for exam

Order Details

Frequency	Duration	Priority	Order Class
1 time imaging	1 occurrence	Routine	Hospital Performed

Original Order

Ordered On	Ordered By
11/23/2016 7:35 PM	Giuseppe T Montagna

Appointments for this Order

11/23/2016 2:00 PM - 45 min LM NIR RM (Resource) Lm 3 Ir Cardiac Cath Ep

Acknowledgement Info

For	At	Acknowledged By	Acknowledged On
Placing Order	11/23/16 1935	Jessica Lok, RN	11/23/16 2049

Verbal Order Info

Action	Created on	Order Mode	Entered by	Responsible Provider	Signed by	Signed on
Ordering	11/23/16 1935	Verbal with readback	Giuseppe T Montagna	Jeremy M Liff, MD	Jeremy M Liff, MD	11/26/16 1556

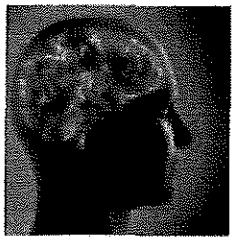
Additional Information

Associated Reports
View Encounter
Priority and Order Details

Order Requisition

IR EMBOLIZATION NEURO BRAIN OR SPINAL CORD (Order #155869500) on 11/23/16

EXHIBIT B



Jeffrey Farkas MD, LLC DBA Interventional Neuro Associates

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM & LIMITED POWER OF ATTORNEY

Assignment of Insurance Benefits -Appointment as Legal Authorized Representative

I hereby irrevocably assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to Jeffrey Farkas MD, LLC DBA Interventional Neuro Associates and their chosen affiliated law firms (hereinafter, "My Authorized Representatives") and I appoint them as my authorized representative with the power to:

- File medical claims with the health plan including filing arbitration/litigation in your name on my behalf against the PIP carrier/health care carrier
- File appeals and grievances with the health plan
- Institute any necessary litigation and/or complaints against my health plan naming me as plaintiff in such lawsuits and actions if necessary (or me as guardian of the patient if the patient is a minor).
- Discuss or divulge any of my personal health information or that of my dependents with any third party including the health plan. I authorize you and your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care providers(s) to release all such information to you about me, including medical reports, x-ray reports, narrative reports, and any other report or information regarding my physical condition.

I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize My Authorized Representatives to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to My Authorized Representatives to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action including litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. I authorize communication with the Provider and his authorized representatives by email and my email address is _____@_____. I understand I can revoke this authorization in writing at any time. I direct all reimbursable medical payments go directly to you, Jeffrey Farkas MD, LLC, DBA Interventional Neuro Associates, "The Practice". I agree to turn over to "The Practice" any checks I receive on behalf of services rendered to me by the providers at "The Practice" and I am aware such payments do not belong to me. I am aware that if I fail to turn over payments to "The Practice" that have been sent to me on behalf of services rendered to me by "The Practice" and if I attempt to keep and profit from such payments and services "The Practice" and it's legal representatives have the right to consider such profiting equivalent to grand theft and prosecute you as one who committed a felony crime. In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is challenged or deemed invalid, I execute this limited/special power of attorney and appoint and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case, in my name, including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney in fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me. I authorize you and or your attorney to receive from my insurer, immediately upon verbal request, all information regarding last payment made by said insurer on my claim, including date of payment and balance of benefits remaining.

A photocopy of this Assignment Authorization shall be as effective and valid as the original.

Or. R[redacted] 10/31/17

SIGNATURE OF PATIENT, PARENT, GUARDIAN OR INDIVIDUAL RESPONSIBLE FOR PAYMENT DATE

EXHIBIT C

CIGNA - PPO
PO BOX 182223
CHATTANOOGA, TN 37422

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE (ID#/DOD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#) ✓

1a. INSURED'S I.D. NUMBER (For Program in Item 1): HCS22718790600

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): [redacted] Temuri

3. PATIENT'S BIRTH DATE MM DD YY: [redacted] SEX M ✓ F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): [redacted] Temuri

5. PATIENT'S ADDRESS (No., Street): [redacted]

6. PATIENT RELATIONSHIP TO INSURED: Self ✓ Spouse Child Other

7. INSURED'S ADDRESS (No., Street): [redacted]

CITY: [redacted] STATE: NY

8. RESERVED FOR NUCC USE

CITY: [redacted] STATE: NY

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO ✓

a. INSURED'S DATE OF BIRTH MM DD YY: [redacted] SEX M ✓ F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO ✓ PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO ✓

c. INSURANCE PLAN NAME OR PROGRAM NAME: CIGNA - PPO

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO ✓ If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 11 21 16 TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): Corrected claim.Original claim #000056929-CGA

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. I67.82 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE: 7 ORIGINAL REF. NO.: 000056929-CGA

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	11	22	16	11	22	16	21	Y	99291	24	a	2200 00	1		NPI	1659638708
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 461672913

26. PATIENT'S ACCOUNT NO.: 110460041278806

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ✓ NO

28. TOTAL CHARGE: $ 2200 00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

J. Liff

SIGNED 02/28/2018 DATE

32. SERVICE FACILITY LOCATION INFORMATION

Lutheran Medical Center INPT
150 55th Street
Brooklyn, NY 11220

a. 1659638708 b.

33. BILLING PROVIDER INFO & PH # (201) 387-1957

Jeffrey Farkas MD, LLC DBA Inte
43 Westminster Avenue
Bergenfield, NJ 07621

a. 1114267929 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CIGNA - PPO
PO BOX 182223
CHATTANOOGA, TN 37422

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APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

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3. PATIENT'S BIRTH DATE MM DD YY: [redacted] SEX M ☑ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial): [redacted] Temuri

5. PATIENT'S ADDRESS (No., Street): [redacted]

6. PATIENT RELATIONSHIP TO INSURED: Self ☑ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): [redacted]

CITY: [redacted] STATE: NY

8. RESERVED FOR NUCC USE

CITY: [redacted] STATE: NY

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

b. RESERVED FOR NUCC USE:

c. RESERVED FOR NUCC USE:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☑

b. AUTO ACCIDENT? YES ☐ NO ☑ PLACE (State) ____

c. OTHER ACCIDENT? YES ☐ NO ☑

10d. CLAIM CODES (Designated by NUCC):

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. INSURED'S DATE OF BIRTH MM DD YY: [redacted] SEX M ☑ F ☐

b. OTHER CLAIM ID (Designated by NUCC):

c. INSURANCE PLAN NAME OR PROGRAM NAME: CIGNA - PPO

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☑ *If yes*, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 11 21 16 TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): Corrected claim.Original claim # 000056930-CGA

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. I67.82 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE: 7 ORIGINAL REF. NO.: 000056930-CGA

23. PRIOR AUTHORIZATION NUMBER:

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	11	23	16	11	23	16	21	Y	99291	24	a	2200 00	1		NPI	1659638708
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 461672913 ☐ ☑

26. PATIENT'S ACCOUNT NO.: 110460041297602

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☑ NO ☐

28. TOTAL CHARGE: $ 2200 00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

J. Liff

SIGNED 02/28/2018 DATE

32. SERVICE FACILITY LOCATION INFORMATION

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Brooklyn, NY 11220

a. 1659638708 b.

33. BILLING PROVIDER INFO & PH # (201) 387-1957

Jeffrey Farkas MD, LLC DBA Inte
43 Westminster Avenue
Bergenfield, NJ 07621

a. 1114267929 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CIGNA - PPO
PO BOX 182223
CHATTANOOGA, TN 37422

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

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4. INSURED'S NAME (Last Name, First Name, Middle Initial): [redacted] Temuri

5. PATIENT'S ADDRESS (No., Street): [redacted]

6. PATIENT RELATIONSHIP TO INSURED: Self ✓ Spouse Child Other

7. INSURED'S ADDRESS (No., Street): [redacted]

CITY: [redacted] STATE: NY

8. RESERVED FOR NUCC USE

CITY: [redacted] STATE: NY

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES NO ✓

a. INSURED'S DATE OF BIRTH MM DD YY: [redacted] SEX M ✓ F

b. RESERVED FOR NUCC USE:

b. AUTO ACCIDENT? YES NO ✓ PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES NO ✓

c. INSURANCE PLAN NAME OR PROGRAM NAME: CIGNA - PPO

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC):

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO ✓ If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. I63.231 B. I67.848 C. I67.82 D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	11	23	16	11	23	16	21	Y	37215		a	33000 00	1		NPI	1609198779
2	11	23	16	11	23	16	21	Y	36223	59	c	32000 02	1		NPI	1609198779
3	11	23	16	11	23	16	21	Y	36226	59	c	32000 00	1		NPI	1609198779
4	11	23	16	11	23	16	21	Y	61650	59	b	20000 00	1		NPI	1609198779
5	11	23	16	11	23	16	21	Y	36245	59	c	5125 00	1		NPI	1609198779
6	11	23	16	11	23	16	21	Y	75898	26 59	a	3600 00	1		NPI	1609198779

25. FEDERAL TAX I.D. NUMBER SSN EIN: 461672913

26. PATIENT'S ACCOUNT NO.: 065702042605562

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ✓ NO

28. TOTAL CHARGE: $ 125725 02

29. AMOUNT PAID: $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

A. Tiwari

SIGNED 02/28/2018 DATE

32. SERVICE FACILITY LOCATION INFORMATION

Lutheran Medical Center INPT
150 55th Street
Brooklyn, NY 11220

a. 1609198779 b.

33. BILLING PROVIDER INFO & PH # (201) 387-1957

Jeffrey Farkas MD, LLC DBA Inte
43 Westminster Avenue
Bergenfield, NJ 07621

a. 1114267929 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CIGNA - PPO
PO BOX 182223
CHATTANOOGA, TN 37422

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE (ID#/DOD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#) ☑

1a. INSURED'S I.D. NUMBER (For Program in Item 1): HCS22718790600

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): [redacted] Temuri

3. PATIENT'S BIRTH DATE MM DD YY: [redacted] SEX M ☑ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial): [redacted] Temuri

5. PATIENT'S ADDRESS (No., Street): [redacted]

6. PATIENT RELATIONSHIP TO INSURED: Self ☑ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): [redacted]

CITY: [redacted] STATE: NY

8. RESERVED FOR NUCC USE

CITY: [redacted] STATE: NY

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☑

b. AUTO ACCIDENT? YES ☐ NO ☑ PLACE (State)

c. OTHER ACCIDENT? YES ☐ NO ☑

10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH MM DD YY: [redacted] SEX M ☑ F ☐

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME: CIGNA - PPO

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☑ If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 11 21 16 TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. I63.231 B. I67.848 C. I67.82 D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	11	23	16	11	23	16	21	Y	75898	26 59	a	3600 00	1		NPI	1609198779
2	11	23	16	11	23	16	21	Y	75898	26 59	a	3600 00	1		NPI	1609198779
3	11	23	16	11	23	16	21	Y	75898	26 59	a	3600 00	1		NPI	1609198779
4	11	23	16	11	23	16	21	Y	75736	26 59	c	1250 00	1		NPI	1609198779
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 461672913 ☑

26. PATIENT'S ACCOUNT NO.: 065702042605562

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☑ NO ☐

28. TOTAL CHARGE: $ 12050 00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

A. Tiwari
SIGNED 02/28/2018 DATE

32. SERVICE FACILITY LOCATION INFORMATION
Lutheran Medical Center INPT
150 55th Street
Brooklyn, NY 11220
a. 1609198779 b.

33. BILLING PROVIDER INFO & PH # (201) 387-1957
Jeffrey Farkas MD, LLC DBA Inte
43 Westminster Avenue
Bergenfield, NJ 07621
a. 1114267929 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CIGNA - PPO
PO BOX 182223
CHATTANOOGA, TN 37422

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE (ID#/DOD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#) ✓

1a. INSURED'S I.D. NUMBER (For Program in Item 1): HCS22718790600

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): [redacted] Temuri

3. PATIENT'S BIRTH DATE MM DD YY: [redacted] SEX M ✓ F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): [redacted] Temuri

5. PATIENT'S ADDRESS (No., Street): [redacted]

6. PATIENT RELATIONSHIP TO INSURED: Self ✓ Spouse Child Other

7. INSURED'S ADDRESS (No., Street): [redacted]

CITY: [redacted] STATE: NY

8. RESERVED FOR NUCC USE

CITY: [redacted] STATE: NY

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO ✓

a. INSURED'S DATE OF BIRTH MM DD YY: [redacted] SEX M ✓ F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO ✓ PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO ✓

c. INSURANCE PLAN NAME OR PROGRAM NAME: CIGNA - PPO

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO ✓ If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

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15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 11 21 16 TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): Corrected claim .Original claim # 000056928-CGA

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. I63.231 B. I67.82 C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE: 7 ORIGINAL REF. NO.: 000056928-CGA

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	11	24	16	11	24	16	21	Y	99291	24	a	2200 00	1		NPI	1659638708
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 461672913 ✓

26. PATIENT'S ACCOUNT NO.: 110460041328894

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ✓ NO

28. TOTAL CHARGE: $ 2200 00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

J. Liff
SIGNED 02/28/2018 DATE

32. SERVICE FACILITY LOCATION INFORMATION
Lutheran Medical Center INPT
150 55th Street
Brooklyn, NY 11220
a. 1659638708 b.

33. BILLING PROVIDER INFO & PH # (201) 387-1957
Jeffrey Farkas MD, LLC DBA Inte
43 Westminster Avenue
Bergenfield, NJ 07621
a. 1114267929 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

EXHIBIT D

LEADING EDGE ADMINISTRATORS

Leading Edge Administrators
14 WALL ST STE 5B
NEW YORK NY 10005-2113

Provider Remittance Summary

[-CC]

Forwarding Service Requested

JEFFREY FARKAS MD, LLC DBA I
43 WESTMINSTER AVENUE
BERGENFIELD NJ 07621

Customer Care Information

If you have any questions regarding this claim, please contact the Fund Office at 1-888-721-2128

Group: HCS
Group #: LEA006003

Date: 05/19/2017
Patient Acct #: 065702042605562

Claim #: 000067123-CGA
Patient: TEMURI[redacted]

Provider: AMBOOJ TIWARI
Enrollee: TEMURI[redacted]
Enrollee ID: HCS227187906

	Dates of Service	Procedure Code	Charged Amount	Not Covered	Reason Code	Provider Discount	Allowable Amount	Deductible Amount	Co-Pay Amount	Co-Insurance	Payment Amount
001	11/23-11/23/2016	37215	$33,000.00	$0.00	755	$31,639.97	$1,360.03	$0.00	$0.00	$0.00	$1,360.03
002	11/23-11/23/2016	36223	$32,000.02	$0.00	755	$31,599.98	$400.04	$0.00	$0.00	$0.00	$400.04
003	11/23-11/23/2016	36226	$32,000.00	$0.00	755	$31,546.03	$453.97	$0.00	$0.00	$0.00	$453.97
004	11/23-11/23/2016	61650	$20,000.00	$0.00	755	$18,524.58	$1,475.42	$0.00	$0.00	$0.00	$1,475.42
005	11/23-11/23/2016	36245	$5,125.00	$0.00	755	$4,819.04	$305.96	$0.00	$0.00	$0.00	$305.96
006	11/23-11/23/2016	75898	$3,600.00	$0.00	755	$3,500.87	$99.13	$0.00	$0.00	$0.00	$99.13
007	11/23-11/23/2016	75898	$3,600.00	$0.00	755	$3,500.87	$99.13	$0.00	$0.00	$0.00	$99.13
008	11/23-11/23/2016	75898	$3,600.00	$0.00	755	$3,500.87	$99.13	$0.00	$0.00	$0.00	$99.13
009	11/23-11/23/2016	75898	$3,600.00	$0.00	755	$3,500.87	$99.13	$0.00	$0.00	$0.00	$99.13
010	11/23-11/23/2016	75736	$1,250.00	$0.00	755	$1,181.85	$68.15	$0.00	$0.00	$0.00	$68.15
	Column Totals		$137,775.02	$0.00		$133,314.93	$4,460.09	$0.00	$0.00	$0.00	$4,460.09

Patient's Responsibility: $0.00

Other Carrier Adjustment $0.00
Total Payment Amount $4,460.09

Procedures

Code	Description
36223	PLACE CATH CAROTID/INOM ART
36226	PLACE CATH VERTEBRAL ART
36245	INS CATH ABD/L-EXT ART 1ST
37215	TRANSCATH STENT CCA W/EPS
61650	EVASC PRLNG ADMN RX AGNT 1ST
75736	ARTERY X-RAYS PELVIS
75898	FOLLOW-UP ANGIOGRAPHY

Remarks

Code	Description
755	THE AMOUNT REPRESENTS THE DIFFERENCE BETWEEN THE PROVIDER'S CHARGES AND THE OUT OF NETWORK ALLOWED AMOUNT. THE MEMBER IS RESPONSIBLE FOR THIS AMOUNT.

Payment Details

Paid To	Check Date	Amount
JEFFREY FARKAS MD, LLC DBA I	05/19/17	$4,460.09

Additional Information

We have selected Pay-Plus Solutions as our ePayment vendor to assist us in quickly transferring payment as well as complying with PPACA Section 1104. To sign up for ePayments using ACH or Credit Card, as well as electronic EOB's (835, Excel, PDF) please visit www.PPSONLINE.COM, email membership@ppsonline.com, or call Pay-Plus' Membership Services at 1-877-828-8834.